

March 20, 2008

# Montana Healthcare Programs Notice

## Physicians, Mid-Level Practitioners and Pharmacies

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### Effexor XR® Dose Consolidation

Effective April 21, 2008, quantity limits will be imposed for Effexor XR® to ensure prescriptions are dispensed in the most cost-effective manner. When a prescription is submitted in excess of the quantity limit, the claim will deny with an edit message notifying the pharmacy the maximum daily dose has been exceeded and to consolidate the dose or call for Prior Authorization.

### Background

Effexor XR® is a mental health drug indicated for once-daily administration and is a relatively flat-priced drug, meaning there is little cost difference between the different strengths of the medication. Effexor XR® has a maximum recommended daily dose of 225mg which can be achieved by combining one 150mg capsule with one 75mg capsule. Immediate release generic venlafaxine is available in five strengths, ranging from 25mg to 100mg, for BID and TID dosing. The following Cost/Dose example is the AWP reported by First DataBank as of March 19, 2008, and is provided for illustration purposes only.

Dose	Cost/Capsule (AWP)	Daily Quantity Limit
37.5mg	\$3.95	1
75mg	\$4.42	1
150mg	\$4.82	1

To request prior authorization, providers must submit the information requested on the attached Request for Drug Prior Authorization Form to the Drug Prior Authorization Unit. The prescriber (physician, etc.) or pharmacy may submit requests by mail, telephone, or fax to:

Drug Prior Authorization Unit  
Mountain Pacific Quality Health Foundation  
3404 Cooney Drive  
Helena, MT 59602  
(406) 443-6002 or (800) 395-7961 (Phone)  
(406) 443-7014 or (800) 294-1350 (Fax)

Any questions regarding this notice can be directed to Wendy Blackwood at (406) 444-2738 or the Medicaid Drug Prior Authorization Unit at (406) 443 6002.

### Contact Information

For claims questions or additional information, contact Provider Relations:

**Provider Relations toll-free in- and out-of-state: 1-800-624-3958**

**Helena: (406) 442-1837**  
**E-mail: MTPRHelpdesk@ACS-inc.com**

Visit the Provider Information website:

**<http://www.mtmedicaid.org>**

# MOUNTAIN-PACIFIC QUALITY HEALTH FOUNDATION

## Request for Drug Prior Authorization

Submitter: ☐ Physician ☐ Pharmacy

Please Type or Print

PATIENT NAME (Last) (First) (Initial)			PATIENT MEDICAID I.D. NUMBER		DATE	OF	BIRTH	
					MONTH	DAY	YEAR	
PHYSICIAN NPI		PHYSICIAN PHONE #	DATES COVERED BY THIS REQUEST					
			FROM TO					
PHYSICIAN NAME			MONTH	DAY	YEAR	MONTH	DAY	YEAR
PHYSICIAN STREET ADDRESS			<b>MAIL, FAX OR PHONE COMPLETED FORM TO:</b>  <b>DRUG PRIOR AUTHORIZATION UNIT</b> <b>MOUNTAIN-PACIFIC QUALITY HEALTH</b> <b>3404 COONEY DRIVE</b> <b>HELENA, MT 59602</b>  <b>(406) 443-6002 or 1-800-395-7961 (PHONE)</b> <b>(406) 443-7014 or 1-800-294-1350 (FAX)</b>					
PHYSICIAN CITY STATE ZIP								
PHARMACY NPI		PHARMACY PHONE #						
PHARMACY NAME								
PHARMACY STREET ADDRESS								
PHARMACY CITY STATE ZIP								
<b>DRUG TO BE AUTHORIZED</b>								
DRUG NAME			STRENGTH		DIRECTIONS			
DIAGNOSIS OR CONDITION TREATED BY THIS DRUG								

<b>LEAVE BLANK - PA UNIT USE ONLY</b>					
REASON FOR DENIAL OF DRUG PRIOR AUTHORIZATION					
IMPORTANT NOTE: In evaluating requests for prior authorization, the consultant will consider the drug from the standpoint of published criteria only. If the approval of the request is granted, this does not indicate that the recipient continues to be eligible for Medicaid. It is the responsibility of the provider of service to establish by inspection of the recipient's Medicaid eligibility card and if necessary, by contact with Consultec to determine if the recipient continues to be eligible for Medicaid.					
CURRENT RECIPIENT ELIGIBILITY MAY BE VERIFIED BY CALLING CONSULTEC AT 1-800-624-3958 or 406-442-1837.					
APPROVAL OR DENIAL STATUS	DENIAL CODE	THERAPEUTIC CLASS	AUTH ID	DATE OF REQUEST	PRIOR AUTHORIZATION NUMBER